

## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

2802-62-012566  
STATE FILE NUMBERDO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

FILED MAR 26 1962

VS 300  
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH  
a. COUNTYb. CITY (If outside corporate limits, give TOWNSHIP only)  
OR TOWN **ST. LOUIS, MISSOURI**

Length of stay in 1b

c. FULL NAME OF (If NOT in hospital, give location)  
HOSPITAL OR INSTITUTION**BARNES HOSPITAL**Inside Limits  
Yes ☐ No ☐2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  
a. STATE **Arkansas** b. COUNTY **Baxter**c. CITY OR TOWN **Mountain Home**Inside Limits  
Yes ☐ No ☐d. STREET ADDRESS (If outside, give location)  
**Henderson Star Route**Reside on Farm  
Yes ☐ No ☐3. NAME OF DECEASED  
(Type or print)

First

Middle

Last

**CLYDE****NMN****CRUTHIS**

## 4. DATE OF DEATH

Month

Day

Year

**MARCH****13****1962**5. SEX  
**Male**6. COLOR OR RACE  
**White**7. Married ☒ Never Married ☐  
Widowed ☐ Divorced ☐8. DATE OF BIRTH  
**9-21-1897**9. AGE (last birthday)  
**64**IF UNDER 1 YEAR  
Months Days Hours Min.

## IF UNDER 24 HR

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
**Engineer**10b. KIND OF BUSINESS OR INDUSTRY  
**Oil**11. BIRTHPLACE (City and state or country)  
**Sorento, Illinois**12. CITIZEN OF WHAT COUNTRY  
**U. S. A.**

## 13a. FATHER'S NAME

**Rufus Cruthis**

## 13b. MOTHER'S MAIDEN NAME

**Mary Holbrook**

## 14. NAME OF HUSBAND OR WIFE

**Sadie Cruthis**15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown) (If yes, give war or dates of service)  
**No**

## 16. SOCIAL SECURITY NO.

## 17. INFORMANT

Address

**Mrs. Sadie Cruthis Mountain Home, Ark.**

## 18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**KLEBSIELLA PNEUMONIA**INTERVAL BETWEEN  
ONSET AND DEATH  
**5-6 DAYS**Conditions, if any,  
which gave rise to  
above cause (a),  
stating the under-  
lying cause last.

DUE TO (b)

**CHRONIC LYMPHOCYTIC LEUKEMIA****7 YEARS**

DUE TO (c)

**204.0**

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☐ No ☐ Unknown19. WAS AUTOPSY PERFORMED?  
YES ☒ NO ☐20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

## 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY  
Hour a.m. p.m.

Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐  
NOT WHILE AT WORK ☐

## 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

## 20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from **FEBRUARY 21, 1962** to **MARCH 13, 1962** and last saw her alive on **MARCH 13, 1962**Death occurred at **8:30 a.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

## 22a. SIGNATURE

(Degree or title)

**M.D.**

## 22b. ADDRESS

**BARNES HOSPITAL**

## 22c. DATE SIGNED

**3/13/62**

## 23a. BURIAL, CREMATION, REMOVAL (Specify)

**Removal**

## 23b. DATE

**3-16-1962**

## 23c. NAME OF CEMETERY OR CREMATORY

**Sunnyside Cemetery**

## 23d. LOCATION (City, town, or county)

**Sorento, Illinois**

(State)

## 24. FUNERAL DIRECTOR

ADDRESS

**Perfetti Funeral Home Sorento, Ill.**

## 25. DATE RECD. BY LOCAL REG.

**MAR 13 1962**

## 26. REGISTRAR'S SIGNATURE

**Lead Smith, M.D.**USE BLACK INK  
OR  
TYPEWRITER RIBBON

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by Not Embalmed, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed John J. Karsely III  
Licensed Embalmer No. 5039

P. O. Address \_\_\_\_\_

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.